DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/25/2009 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
IDENTIFICATION IDENTIFICATION RUMBER:		A. BUILDI		COMPLETED	
	09G031	B. WING		40/0	0/2000
ROVIDER OR SUPPLIER		57	REET ADDRESS CITY STATE ZIP CODE		9/2009
NITY MULTI SERVICE	S, INC		4314 9TH STREET NW		
(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE	(X5) COMPLETIO DATE
INITIAL COMMENT	rs	W 000			
received written not this agency. Accordance alleged incident occupapproximately 11:20 described that a directly in the bed with C	diffication of an incident from ding to the notification, the curred on August 18, 2009 at D.P.M. The incident report ect care staff observed Client tilent #1. Client #2 had her		GOVERNMENT OF THE DISTRICT OEPARTMENT OF HEAL HEALTH REGULATION AOMIN	TH STRATION 2NO FLOOR	
information obtained review, an onsite invinitiated on October with federal regulate the Investigation was the group home, Internal Management, direct Administrative and	d from the administrative vestigation [#09-6465] was 5, 2009 to verify compliance bry requirements. Findings of re based on observations in erviews with the group home care staff, and the review of dabilitation records to include				
could not substantia #2 had been exhibite However a determin facility failed to be in standard level requir as evidenced by thro 483.410(a)(1) GOVE	te that the behavior of Client ed prior to this incident. ation was made that the compliance with the ements in Client Protections bughout this report.	W 104			
rne governing body budget, and operating	must exercise general policy, ag direction over the facility.				
Based on interview a governing body failed	and record reviews, the				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR DEFICIENCY REGULATORY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS On August 20, 2009, the State Agency (SA) received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that a direct care staff observed Client #2 in the bed with Client #1. Client #2 had her finger inserted in Client #1's rectum. Due to the nature of the incident and the information obtained from the administrative review, an onsite investigation [#09-6465] was initiated on October 5, 2009 to verify compliance with federal regulatory requirements. Findings of the investigation ware based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system. As a result of this investigation, the State agency could not substantiate that the behavior of Client #2 had been exhibited prior to this incident. However a determination was made that the facility failed to be in compliance with the standard level requirements in Client Protections as evidenced by throughout this report. 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) INITIAL COMMENTS On August 20, 2009, the State Agency (SA) received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that a direct care staff observed Client #2 in the bed with Client #1. Client #2 had her finger inserted in Client #1's rectum. Due to the nature of the incident and the information obtained from the administrative review, an onsite investigation [#99-6465] was initiated on October 5, 2009 to verify compliance with federal regulatory requirements. Findings of the investigation ware based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system. As a result of this investigation, the State agency could not substantiate that the behavior of Client #2 had been exhibited prior to this incident. However a determination was made that the facility falled to be in compliance with the standard level requirements in Client Protections as evidenced by throughout this report. 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not mat as evidenced by: Based on interview and record reviews, the governing body falled to exercise general policy	ROVIDER OR SUPPLIER NITY MULTI SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS On August 20, 2009, the State Agency (SA) received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that a direct care staff observed Client #21 in the bed with Client #1. Client #2 had her finger inserted in Client #1's rectum. Due to the nature of the incident and the information obtained from the administrative review, an onsite investigation (#09-6465) was initiated on October 5, 2009 to verify compliance with federal regulatory requirements. Findings of the investigation were based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system. As a result of this investigation, the State agency could not substantiate that the behavior of Client #2 had been exhibited prior to this incident. However a determination was made that the facility failed to be in compliance with the standard level requirements in Client Protections as evidenced by throughout this report. 483.410(a)(1) GCVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not mat as evidenced by: Based on interview and record reviews, the governing body falled to exercise general policy	ROYIDER OR SUPPLIER NITY MULTI SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS On August 20, 2009, the State Agency (SA) received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that a direct care staff observed Client #2 in the bed with Client #1. Client #2 had her finger inserted in Client #15 rectum. Due to the nature of the incident and the information obtained from the administrative review, an onsite investigation (#09-8465) was initiated on October 5, 2009 to verify compliance with federal regulatory requirements. Findings of the Investigation ware based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system. As a result of this investigation, the State agency could not substantiate that the behavior of Client #2 had been exhibited prior to this incident. However a determination was made that the facility failed to be in compliance with the standard level requirements in Client Protections as evidenced by throughout this report. 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.

Art following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

12-04-2009 3 /15 PHINTED: 11/25/2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES				FORM OMB NO	APPROVED 09380391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	i i i i i i i i i i i i i i i i i i i	Ę	CONSTRUCTION	(X3) DA1	TE SURVEY PLETED
		09G031	B.WING A			10/0	9/2009
NAME OF P	ROVIDER OR SUPPLIER		S	REE	T ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY MULTI SERVICE	ES, INC			4 9TH STREET NW SHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 149	findings include: 1. The facility's government in the incident Manage a thorough internal in with the agency's pw154) 2. The facility's government reported this incident policy incident policy. The facility's government care staff partitionanagement reporter accordance with the procedures, (See W	in the facility. (Client #1) The ming body failed to ensure that ment Coordinator completed vestigation in accordance olicy and procedures. (See eming body failed to ensure its lent timely in accordance with the cy and procedures. (See W 1 49) eming body failed to ensure its cipated in ongoing incidenting in eagency's policy and	W 104		 In the future the Incident Management Coordinator complete a thorough inter investigation. Cross reference 1379 Cross reference 1222 	nal .	12/2/09 10/23/09 10/23/09
	policies and procedur mistreatment, neglec	t or abuse of the client.		1.	with any other individual.		8/19/09
	Based on observation the facility falled to er	not met as evidenced by: n, interview, and record review, nsure that the agency's olicles were implemented for		2.	Client #1's one-to-one protoc updated and signed by all staf work with Client #1.		11/1/09
		hat resided in the facility. (Client		3.	Staff will receive training on land Abuse.	Neglect	11/1/09
	The finding includes:				•		ŀ
:	The facility failed to er "Incident Managemer	nsure the implementation of its nt" policy as outlined					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/25/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G031 NAME OF PROVIDER OR SUPPLIER 10/09/2009 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 4314 9TH STREET NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID Ю PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 149 Continued From page 2 W 149 below: On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the facility's Qualified Mental Retardation Professional (MRCP) that she observed Client #2 In the bed with Client #2's finger inserted in Client #1's rectum. On October 19, 2009 at approximately 4:08 P.M., a phone interview was conducted with the direct care (Staff #1), who observed this incident. Staff #1 revealed that Cilent #1 and Client #2 shared a bedroom at the time of this incident. According to Staff #1, Client #2 no longer shares a bedroom with Client #1. Client #2 was given a bedroom alone. Further Interview with Staff #1 revealed that the agency's incident policy was to report any unusual incident immediately to the management staff. Reportedly, Staff #1 walted to report her observation to management the following day when she arrived for duty at 3:30 P.M. The incident report was dated July 19, 2009 and was not reported until 5:00 P.M. on the proceeding day, which was approximately 17 hours later after she observed the incident. Staff #1 admitted that she falled to implement the agency incident reporting policy as she was trained to do. It should be noted that Staff #1 stated that she asked Client #2 to return to her bed. Client #2 responded by going to her bed and putting the top

bed cover over her head.

An Interview with the Residential Manager (RM) as a part of the initial administrative review

5/15 11/26/2000

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

PRINTED: 11/25/2009 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY IPLETED
		09G031	B. WING			10/0	9/2009
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	S, INC		431	ET ADDRESS, CITY, STATE, ZIP CODE 14 9TH STREET NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 149	#1 informed her that out loudly on the night sitting in the office got up from the desk check out what was Client #2 in Client BM, the staff did not management staff areport to document Reportedly, Staff # had not encountered before and was uncountered to the Recording to the R	25, 2009 revealed that Staff at she heard Client #1 yelling ght of the incident. She was area on the same floor. She cand went to her bedroom to shappening and discovered #1 's bed. According to the ot immediately notify and/or generate an incident her observations. 1 informed the RM that she ed a situation of this nature elear on what she was to do. M, " Staff #1 had access to and the ciock, on a 24 hour	W 1	49			
W 153	was assigned a one behavioral concerns Staff #1, whom was	urther noted that Client #1 e on one counselor for her s. According to interview, the assigned one on one n break at the time of this TREATMENT OF	W 18	53 (Cross reference W149		11/1/09
	mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of sect or abuse, as well as source, are reported administrator or to other se with State law through ures.	,	:			
	Based on staff interfacility failed to ensineglect/abuse were r	not met as evidenced by: view and record review, the ure that all allegations of reported timely as required by ed by DC regulation (22					

6/15

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 11/25/2009 M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE	O. 0938-0391 SURVEY LETED
		09G031	B. WING			
СОММИ	PROVIDER OR SUPPLIER NITY MULTI SERVICE		j	TREET ADDRESS, CITY, STATE, ZIP 4314 9TH STREET NW WASHINGTON, DC 20011		09/2009
(X4) ID PREFIX TAG	I CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	DN SHOULD BE HE APPROPRIATE	COMPLETION DATE
	The finding includes Interview with the Quarterview with the Quarterview with the Quarterview with the Quarterview with the finding includes revealed the facility of sexual advances of menagement timely. On August 20, 2009, written notification of According to the notification Profession another client in the Ecilent had her finger in the transport of the Initial admit August 25, 2009, revenient that she heard Client area on the sand the night of the Incide office area on the sand he desk and went to what was happening ecilent #1's bed. According the RM that she had not this nature before a ras to do. According the resident and the RM that she had not this nature before a ras to do. According	Section 3519.10), for one of ang in the facility. (Clients #1) i: uaiified Mental Retardation and review of the facility's on October 5 at 1:45 PM, failed to report an allegation to the administrator and other as evidenced below: the State Agency received an incident from this agency. Fication, the alleged incident 18, 2009 at approximately dent report described that on pproximately 5:00 P.M. a red to the Qualified Mental and that she observed and that she observed and the process of the context of the cont	W 153			

7/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/25/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()40 (1.0)		(X3) DATE SURVEY COMPLETED
		09G031	B.WING		10/09/2009
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	s, INC	4	REET ADDRESS, CITY, STATE, ZIP CODE 1314 9TH STREET NW WASHINGTON, DC 20011	10/00/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION PRIATE DATE
W 153	Continued From page	-	W 153		
W 154	hour basis by teleph 483.420(d)(3) STAFI CLIENTS		W 154		
	violations are thorou		· ,	1. Cross reference W104	12/2/09
		not met as evidenced by: and record review the facility		2. Cross reference 1379	10/23/09
	falled to ensure that abuse of a client residing in the facility was thoroughly investigated for one of			3. Cross reference W104	11/1/09
	the six clients residi (Client #1)			4. Cross reference W104	11/1/09
	The finding includes	:			
		ensure that the reported vas Investigated thoroughly :	·		
Ì	written notification of a According to the notification of a occurred on August 11:20 P.M. The included August 19, 2009 at a direct care staff report Retardation Profession another client in the base.	the State Agency received an incident from this agency. fication the alleged incident 18, 2009 at approximately ent report described that on approximately 5:00 P.M. a red to the Qualified Mental ional that she observed bed with Client #1. The other r inserted in Client #1's		•	
	August revealed that heard Client #1 yellir the incident and went the investigative repo	Residential Manager on Staff #1 explained that she g out loudly on the night of t to her bedroom. However, ort did not specify how Staff ist the Client #1 when she			

		· ·						
5889287	TMENT OF HEALTL	AND III BAAN OFFI COM			06:20:03 a.m.	12-04	1-2009 DDINITER	8 / 15): 11/25/200 9
CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVE
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		PLE CONSTRUCTION	 ir .	(X3) DATE 8 COMPL). 0938-039 [.] BURVEY ETED
		09G031	B. WI	IG				
NAME OF	PROVIDER DR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP C	ODE	10/0	09/2009
COMMU	NITY MULTI SERVICE	<u> </u>		4314 9TH STREET NW WASHINGTON, DC 20011				
(X4) ID PREFIX TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOL E APPRO	H D DE	(X5) COMPLETION DATE
	discovered Client ### RM, Staff #1 falled to management staff. Immediately general document her observed ated July 19, 2009, Indicated that an Incogenerated until 5:00 approximately 17 hosoccurred. The staff had not encounter a and was not clear or According to the RM to management around to management around the staff in January 2009 agency's incident materialing was not effect.	In her bed. According to the o irnmediately notify In addition, the staff failed to be an incident report to vation. The Incident report which was the following day, ident report was not P.M., which was urs after the incident person explained that she situation of this nature before a what she was to do. the staff person had access and the clock or on a 24-hour rice training logbook on the that the agency trained all and July 2009 on the nagement system. This stive.	W 1	54				

occurred. 2. The rationale of the direct care staff that

FORM CMS-2567(02-89) Previous Versions Obsolete

On October 5, 2009 at approximately 2:34 P.M., a review of the agency's internal investigation falled to provide that the following details were included and documented in the internal investigation:

 Client #1 was assigned as the one on one staff person. The investigation failed to explain where the one to one staff was at the time this incident

discovered this incident for not reporting this situation immediately to management staff on

Event IO: 607K11

Facility ID: 09G031

If continuation sheet Page 7 of 10

06:20:19 a.m.

12-04-2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED**

CENTERS FOR MEDICARE 8, MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES **B416** CDNSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED RIDG 09G031 B. WING 10/09/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4314 9TH STREET NW COMMUNITY MULTI SERVICES, INC** WASHINGTON, DC 20011 (X4) ID **SUMMARY STATEMENT OF DEFICIENCIES** ID PROVIDERS PLAN OF CORRECTION COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 154 W 154 Continued From page 7 call. 3. The investigation did not provide evidence of a clear explanation as to where the three staff on duty was in the group home at the time of the incident to help clarify who else may have witnessed the incident. 4. The Internal investigation did not clearly describe how the staff intervened to assist the Client #1. W 159 W 159 Staff will continue to receive ongoing 483.430(a) QUALIFIED MENTAL training on Incident Management Policies RETARDATION PROFESSIONAL & Procedures. In the future, a Each client's active treatment program must be comprehensive test will be given to ensure Integrated, coordinated and monitored by a that the Incident Management training was qualified mental retardation professional. effective. All incidents will be reported in a timely manner to be generated within twenty-four hours. Staff will receive This STANDARD is not met as evidenced by: additional training on the Incident Based on observations, Interviews with the 10/23/09 Qualified Mental Retardation Professional Management Policy. (QMRP) and record review, the QMRP falled to ensure integration, coordination, and monitoring of client's active treatment regimen for one of the six clients residing in the facility. (Client #1) The findings include: 1. The QMRP falled to ensure that staff implemented the agency incident management policies consistently. (See W149)

FORM CMS-2567(02-99) Previous Versions Obsolete

W 189

2. The QMRP failed to ensure that each staff received effective training on the facility's incident

management training in accordance with the

483.430(e)(1) STAFF TRAINING PROGRAM

agency's policies. (See W188)

Event ID: 607K11

Facility ID 09G031

W 189

If continuation sheet Page 8 of 10

06:20:36 a.m.

12-04-2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES -2009 10 /15 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		BUK	CONSTRUCTION		ATE SURVEY APLETED
		096031	BWNG			10/	09/2009
COMMUN	ROVIDER OR SUPPLIER TTY MULTI SERVICE	s, INC		4	REET ADDRESS, CITY, STATE, ZIP CODE 314 9TH STREET NW /ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	K	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 189	initial and continuin	rovide each employee with g training that enables the his or her duties effectively,	W 1		Cross reference W159		10/23/09
	Based on observation review, the facility from the facility from the properties of the facility of the facilit	not met as evidenced by: n, staff Interview, and record alled to ensure that each provided with adequate the employee to perform his vely, efficiently and of one staff in the facility.		-	Closs reference w 139		10/25/09
	that all fadlity staff re	9] The QMRP falled to ensure eceived effective training that tation of the incident					
	written notification of According to the not occurred on August 11:20 P.M. The Indo August 19, 2009 at direct care staff repo Mental Retardation Fobserved another Cl	the State Agency received an incident from this agency. ification the alleged incident 18, 2009 at approximately lent report described that on approximately 5:00 P.M. a rited to the facility's Qualified Professional (MRCP) that she lent #2 in the bed. Client #2 and in Client #1's rectum.					
	Immediately notify method staff falled to in incident report to document to document to document report dated	If, the Staff #1 falled to lanagement staff. In addition, mediately generate an ument her observation. The July 19, 2009, was not P.M. on the proceeding day,			· ·		

06:20:52 a.m.

12-04-2009

11 /15

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 11/25/20)0 9
STATEMENT	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES				OMB NO	M APPROV 2. 0938-03	ED 191
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G031	B. WI	NG	·			
	OVIDER OR SUPPLIER TY MULTI SERVICE	S, INC			TREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011	10/	09/2009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	INGE	(X5) COMPLETIC DATE	NC
wind the nation of the nation	neident occurred. Finat she had not end ature before and wood of the staff person had round the clock or deceived training on eview of the in-sendame day confirmed a staff in January 20 gency's incident ma	nately 17 hours after the Reportedly, the staff explained countered a situation of this as not clear on what she was riew with the RM revealed that access to management on a 24-hour basis and had incident management. Vice training logbook on the that the agency had trained 1009 and July 2009 on the inagement system. This citive. Additional training	W	188				

06:21:04 a.m.

12-04-2009

PRINTED: 11/25/2009 FORM APPROVED

Health	Regulation Administra	ation		-		FORM	APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	111-003-0032	STREET AD	DRESS CITY	, STATE, ZIP CODE	10/0	9/2009
l	JNITY MULTI SERVICE	es, inc	4314 9TH	STREET N	rw .		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	E1 1) 1	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOUD BE	(X5) COMPLETE DATE
1 000	INITIAL COMMENT	rs		1 000			
	written notification o) P.M. The Incident rugust 19, 2009 at P.M. a direct care station Mental Retardal by that she observed with Resident #1 The	s alleged eport aff another				·
	Due to the nature of information obtained review, the Departme Regulation and Licen initiated an investigat October 5, 2009. Thinvestigation were ba group home, interview management, direct of Administrative and Hatthe agency's incident	from the administrate of Health (DOH) is a sing Administration (tion [#09-6465] was defindings of the used on observations we with the group howare staff, and the reabilitation records to	Health (HRLA) on in the me view of				
	As a result of the find not substantiate that the pattern of Resident #2 as a violation of the rigeported in this incided determination was made incompliance with throughout this report.	the sexual allegation 2's behavior and cont ghts of Resident #1 a nt. However, a ade that the facility fa iocal state requireme	was a linued as				
1 222 3	3510.3 STAFF TRAIN	IING	1	222			
	There shail be continurations programs school	ous, ongoing in-serveduled for all persona	ice nel.				
Regulati	on Administration				A+-		
SKATORY D	IRECTOR'S OR PROVIDER	SUPPLIER REPRESENTAT	īve's signat	URE	agran Ducito		DATE /
TE FORM			ű égg	607	KIN MILLED	If continuation	14 (1) 9 sheet fold

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2)MUTRE A BUILDING		(X3) DATE SURVEY COMPLETED		
		HFD03-0052		B WING		10/09/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE	
	ITY MULTI SERVICE	·		Wengopt	2001.	
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORMA		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE PRIATE DATE
Ì	Based on observativerification, the Gi-continuous, ongoing were conducted for The finding included The Gi-MRP falled imanagement training below: Interview with the Riversealed that Staff inclient #1 yelling our incident and went to However, the Invest how Staff #1 interview when she discovered According to the Rimmediately notify the addition, Staff #1 far an incident report to the incident report was the following dareport was not gen approximately 17 hoccurred. Reported she had not encount before and was not a According to the Riversealed to management are basis. Review of the in-sensame day confirmed staff in January 200	met as evidenced by ions, interview and re IMRP failed to ensure in-service training properties one of the sixteen part of the esidential Manager on the esidential Manager on the esidential Manager on the esidential Manager on the collent #1's bedroor to assist the Client #1's bedroor to assist the Client #2 in her bedroof the management stated in the esident to immediately to document her observed as the staff explained as the ered a situation of this clear on what she was a the staff person has und the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency's traff explained and the clock on a 2 wice training logbook that the agency traff explained and the clock on a 2 wice training logbook that the agency traff explained and the clock	ecord e pgrams ersonnel. ent denced August e heard of the m. especify ient #1 ed. ff. In generate ervation. y, which noddent M., ant ed that es to do. d access 4-hour on the ined all the		Staff will continue to receive ongeraining on Incident Management & Procedures. In the future, a comprehensive test will be given that the Incident Management Traeffective.	Policies to ensure
ealth Regu a	ition Administration				171/44	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(XZ)MULTIRU A BUILDIN		(X3) DATE SURVEY COMPLETED
		HFD03-0052		B WING		10/09/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	NITY MULTI SERVIC	CES, INC	49 431 (374)	e ^{rr} (was-neady	ומבכ	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCI CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE OPRIATE DATE
I 222	Continued From p	age 2		I 222		
	Additionally staff v Incident reporting : September 25, 20	vas trained on the ag system and procedure 09.	gency es on			
I 379	3519 10 EMERGE	:NCTES		I 379		
	In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Fadilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.			In the future, all incidents will be in a timely manner, and an incide will be generated within twenty-for the next work day. Staff will radditional training on the Inciden Management Policy.	ent report Four hours receive	
	Based on staff interfacility failed to ensing reported immediate other officials in accrequired by DC registration 3519.10), residing in the facility.	•	v, the vere or to aw as pter 35			
	The finding include	s:				
	Professional (QMRF investigative report revealed the facility allegation of sexual	Qualified Mental Retains and review of the real son October 5 at 1: real failed to immediately all advances to manages evidenced below:	facility's 45 PM, report			
:	written notification	9, the State Agency red of an incident from t to the notification the	his			
ATE FORM	een manning GUAT		•	ees 6	507K11	If continuation sheet 3 o

Health Regulation Administration

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING HFD03-0052 NAME OF PROVIDER OR SUPPLIER 10/09/2009 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 4314 9TH STREET NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX TAG DATE **OEFICIENCY**) 1379 Continued From page 3 1379 incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the Qualified Mental Retardation Professional (QMRP) that she observed another client in the bed with Client #1. The other client had her finger inserted in the Cilent #1's rectum. interview with the Residential Manager (RM) as a part of the initial administrative review process on August 25, 2009 revealed that Staff #1 informed her that she heard Client #1 yelling out loudly on the night of the incident. She was sitting in the office area on the same floor. She got up from the desk and went to Client #1's bedroom to check out what was happening and discovered Client #2 in Client #1 bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her observations. Reportedly Staff #1 informed the RM that she had not encounter a situation of this nature before and was unclear on what she was to do. According to the RM, "Staff #1 had access to management around the clock, on a 24 hour basis by telephone". lealth Regulation Administration